Department of Services for Children Youth and Their Families
State of Delaware

CS 005	DCMHS APPEAL POLICY		
Authored by:	Lynn M. Banks, MSW, LCSW	Title: Director of Quality Improvement	
Approved by:	Susan Cycyk, M. Ed., CDC	Title: Division Director	
Signature:	Susan Cycyk	Date Adopted: 9/17/97	
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PURPOSE

The Division of Child Mental Health Services (DCMHS) establishes this policy to define formal appeals and state the process by which an appeal is to be made.

SCOPE

This policy applies to all DCMHS staff, substance abuse clients age fourteen years or older, parents/legal guardians, legal representative of the client, and service providers for DCMHS clients.

POLICY STATEMENT

It is the policy of the Division of Child Mental Health Services to provide an appeal process through which DCMHS service providers, substance abuse clients age fourteen years or older, parents/legal guardians, or legal representatives for clients may request reconsideration of those decisions identified by this policy as appropriate for appeal. Appeals will be processed in a manner that is timely and safeguards the rights of the appellant. Staff shall ensure that no appellant will experience any form of retaliation for registering an appeal.

All appeals must be consistent with the Client Eligibility Policy (CS 001) and the Clinical Services Management Policy (CS 004). The appeal procedures for Psychiatric Hospitals and all other facilities certified by the Division of Child Mental Health Services as Medicaid 'Psych Under 21' facilities will conform to Federal Medicaid regulations. Other appeal procedures shall be consistent with Federal Medicaid regulations and DSCYF policy.

It is the intent of the Division to resolve concerns about client care at the lowest level possible. If the issue is not satisfactorily resolved at this point, an appeal, either written or oral must be submitted and will follow the DCMHS Appeal Procedure accompanying this policy

Level of care decisions, denial of a continued stay, and eligibility may be appealed by a parent/legal guardian, legal representative for the client, by a substance abuse client age fourteen years or older, or by a provider with the consent and approval of the child' parent or legal guardian. Providers, where appropriate, are encouraged to assist clients and families as advocates in the submission of an appeal.

Services currently being provided the child may be continued at the request of the client, parent, legal guardian or legal representative pending resolution of the appeal. However, if the appeal is denied the appellant may be required to pay the costs of the service provided from the time of DCMHS' denial to the date of client discharge.

DCMHS staff have the obligation to explain to providers, substance abuse clients age fourteen years or older, parents or legal guardians their rights regarding appeals. Appeal rights for client, parent or legal guardians will be addressed in the Client Handbook and at any point that the appellant is clearly dissatisfied with services authorized by a clinical services treatment team leader or an eligibility decision.

When DFS or DYRS has legal custody, staff in disagreement with DCMHS decisions should use the DSCYF case dispute resolution procedures instead of the appeal procedures.

All appellants are to be informed of their right to receive assistance from the DCMHS Quality Improvement Unit in the formulation of a written appeal and for those clients receving medicaid, the right to appeal directly to DHSS Medicaid Office at any point in the appeal process.

DOCUMENTATION

Copies of all formal appeals, formal responses, outcomes and notification letters will be maintained by the DCMHS Quality Improvement Unit.

OI/QA MEASURES

Aggregate reports on provider appeals are provided by the Quality Improvement Director to the Quality Management Committee at least annually. The will report identify significant findings and/or recommendations.

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	DCMHS APPEAL PROCEDURE		
Authored by:	Lynn M. Banks, MSW, LCSW	Title: Director of Quality Improvement	
Approved by:	Susan Cycyk, M. Ed., CDC	Title: Division Director	
Signature:		Date Adopted: 9/17/07	
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Use of this procedure assumes that informal attempts to resolve the issue with a supervisor have failed and that an appeal, either written or oral, has been received.

Matters appropriate for appeal are level of care decisions, continued stay, and eligibility determinations.

I. Provider appeals for reconsideration of continued stay authorization and level of care decisions are made as follows:

A. Psychiatric hospitals and all other facilities certified by the Division of Child Mental Health Services as Medicaid 'Psych Under 21' facilities (42 CFR, Subpart 456.236).

An appeal of a continued stay denial must be made prior to the expiration of the client's current service authorization.

Step One:

In the course of routine business, CSMT procedures follow the steps below for authorization of services for Psych under 21 facilities:

- A subgroup of the Quality Management (QM) Committee that includes at least one physician automatically reviews all CSMT decisions in which a case does not meet clinical criteria for continued stay.
- If this QM subgroup determines that a continued stay is not needed, they notify the recipient's attending or staff physician and give him/her an opportunity to present additional information before finalizing the decision.
- If the provider physician does not present additional information or clarification of the need for continued stay within two (2) business days of notification, the decision of the subgroup is final.
- Written notification of the decision to the provider physician, prior to the expiration of the continued stay review date.

Step Two:

- If the provider physician presents additional information or clarification, at least two physicians appointed by the DCMHS Utilization Management Committee, one of whom is knowledgeable in the treatment of mental disease, will review the request for continued stay.
- If the appeal is denied, then the decision must be communicated to the provider, in writing, with a copy to the Quality Improvement Unit and the client or his/her parent or legal guardian. The notification letter is to be sent by certified mail.
- If the client for whom service is requested is Medicaid eligible, the notification is to include:
  - ► the appeal determination,
  - ► the reason for the decision,

- ▶ the right to appeal this decision, in writing or orally, to the DCMHS Division Director within five (5) business days from the event or the denial precipitating the appeal,
- ▶ the right to request a Fair Hearing with the DHSS Medicaid office at any time during the process,
- ▶ contact information for the Medicaid Fair Hearing Office,
- ▶ the circumstances under which an expedited appeal is available and how to make the request,
- ▶ the right to have the service continue pending resolution of the appeal,
- ▶ how to request continued service,
- ▶ notification that the appellant may be required to pay the costs of this service if the appeal is denied,
- ▶ the right to request assistance from the DCMHS Quality Assurance (QA) Administrator in the formulation of the appeal, and
- ▶ the QA Administrator's telephone number.

- For non-Medicaid eligible clients, the decision at Step Two is final.
- DCMHS may extend the timeframe of this appeal up to fourteen (14) calendar days of this appeal.
- In the event of an extension, written notice must be provided to the appellant and is to include:
  - ▶ the reason for the extension, and
  - ▶ the appellant's right to grieve the extension.

Step Three

- If the provider appeals the Step Two denial to the DCMHS Division Director, the Division Director or his/her designee will review the appeal and make a final decision.
- If the appeal is denied, then the decision must be communicated to the appellant, in writing, within five (5) business days of receipt of the appeal with a copy to the Quality Improvement Unit and the client or his/her parent or legal guardian. The notification letter is to be sent by certified mail.
- The notification is to include:

  - ▶ the appeal determination,
  - ▶ the reason for the decision,
  - ▶ the right to request a Fair Hearing with the DHSS Medicaid office at any time during the process,
  - ▶ contact information for the Medicaid Fair Hearing Office,
  - ▶ the right to have the service continue pending resolution of the appeal,
  - ▶ how to request continued service, and
  - ▶ notification that the appellant may be required to pay the costs of this service if the appeal is denied.

- DCMHS may extend the timeframe of this appeal up to fourteen (14) calendar days of this appeal
- In the event of an extension, written notice must be provided to the appeal and is to include:
  - ▶ the reason for the extension, and
  - ▶ the appellant's right to grieve the extension.

B. Services at all other levels of care including facilities not certified as "Psych Under 21"

An appeal of a continued stay denial must be made prior to the expiration of the client's current service authorization.

The appellant is encouraged to attempt to resolve the dispute with the Clinical Services Management Team Leader at the Step One, or informal appeal level, which is as follows:

Step One

The informal initial request for reconsideration of a service denial is presented to the DCMHS Clinical Services Management Team Leader. This appeal may be written or oral. In the event that a review of this appeal results in a denial, then the DCMHS Team Leader is to provide written notification to the appellant to include the following information:

- the appeal finding
- the right to appeal this decision to the DCMHS Director of Clinical Services Management within (10) business days from the denial precipitating the appeal,
- the reason for the decision
- For Medicaid eligible clients, the notification is also to include the appellant's right to:
  - request a Fair Hearing with the DHSS Medicaid office at any time during the process,
  - contact information for the Medicaid Fair Hearing Office,
  - the circumstances under which an expedited appeal is available and how to make the request,
  - the right to have the service continue pending resolution of the appeal,
  - how to request continued service,
  - notification that the appellant may be required to pay the costs of this service if the appeal is denied,
  - request assistance from the DCMHS Quality Assurance (QA) Administrator in the formulation of the appeal, and
  - the QA Administrator's telephone number.

A copy of the denial letter is to be sent to the Quality Improvement Director at the time such notification is sent to the appellant.

Step Two

A Step Two Appeal may be made either in writing or orally. Upon receipt of an appeal of the Team Leader's decision, the DCMHS Director of Clinical Services Management will appoint two (2) DCMHS staff members licensed as mental health practitioners and not involved in the informal appeal, to review the Step Two Appeal which is to include records review, discussion with the appellant, CSM staff and provider as necessary.

The appellant is to be notified of the time, date and location of the appeal review.

The appeal review participants will advise the Director of Clinical Services Management of the finding and will, within ten (10) business days of receipt of the appeal, provide written notification to the appellant. The notification is to be sent by certified mail and is to include the following information:

- the appeal finding
- the right to appeal this decision to the DCMHS Quality Improvement Director within (10) business days from the denial precipitating the appeal,
- For Medicaid eligible clients, the notification is to include the appellant's right to:
  - request a Fair Hearing with the DHSS Medicaid office at any time during the process,
  - contact information for the Medicaid Fair Hearing office,
  - the circumstances under which an expedited appeal is available and how to make the request,
  - the right to have the service continue pending resolution of the appeal,
  - how to request continued service,
  - notification that the appellant may be required to pay the costs of this service if the appeal is denied,
  - request assistance from the DCMHS Quality Assurance (QA) Administrator in the formulation of the appeal, and
  - the QA Administrator's telephone number.

A copy of the appeal finding letter is to be sent to the Quality Improvement Director at the time such notification is sent to the appellant.

Step Three

A Step Three Appeal may be made either in writing or orally. Upon receipt of a Step Three appeal, the Quality Improvement Director will designate two DCMHS staff who are licensed as mental health practitioners and not parties to the DCMHS decisions in the two previous appeal step to conduct the Step Three Appeal. It is recommended that one of the appeal panel participants be a Board Certified Psychiatrist. The appeal review is to include a records review, discussion with the appellant, CSM staff, and provider as necessary.

The appellant is to be notified of the time, date and location of the appeal review.

The appeal participants will advise the QI Director of their finding and will provide written notification of the finding to the appellant by certified mail within (10) business days of receipt of the appeal with a copy to the Quality Improvement Director.

If the appeal is denied, for Medicaid eligible clients, the notification is to identify the appellant's right to request a Fair Hearing by DHSS Medicaid and include contact information for the DHSS Medicaid Fair Hearing Office. For non-Medicaid eligible clients, this decision is final.

II. Eligibility Appeals

When an applicant for DCMHS services is determined not to be eligible for those services, DCMHS Intake staff will provide written notification to the appellant to inform him/her of:

- the right to appeal the decision to the Quality Improvement Director, and
- the right to request the assistance of the DCMHS Quality Assurance Administrator in the formulation of a written appeal.

Medicaid eligible clients will be informed of their right to request a Fair Hearing by DHSS Medicaid at any time during this process which is to include contact information for the Medicaid Fair Hearing Office.

Step One:

Upon receipt of a Step One Appeal, the Director of Intake will convene a review panel of two licensed mental health practitioners. The appellant is to be notified of the time, date and location of the appeal review.

The decision of this panel will be provided in writing to the appellant within ten (10) business days of receipt of the appeal. The notification is to be sent by certified mail. If the decision is denied, the appellant will be notified of his/her right to appeal this decision in writing within ten (10) business days of receipt of the denial and to request assistance from the DCMHS Quality Assurance (QA) Administrator in the formulation of the appeal.

- For Medicaid eligible clients, the notification is to include the appellant's right to:
  - appeal this decision, in writing or orally, to the DCMHS Division Director within ten (10) business days from the denial precipitating the appeal,
  - the reason for the decision,
  - request a Fair Hearing with the DHSS Medicaid office at any time during the process,
  - contact information for the Medicaid Fair Hearing Office,
  - the circumstances under which an expedited appeal is available and how to make the request,
  - the right to request assistance from the DCMHS Quality Assurance (QA) Administrator in the formulation of the appeal, and
  - the QA Administrator's telephone number.

Step Two:

- Upon receipt of a Step Two Appeal, the QI Director will convene a review panel consisting of the Director of Specialized Services and the PBH Consulting Psychiatrist or their designees.
- The decision of this panel will be provided in writing to the appellant within ten (10) business days of receipt of the appeal.
- If the decision is denied, the QI Director is to provide written notification of the appellant's right to appeal this denial to the DCMHS Director within twenty (20) business days from receipt of the denial.
- For Medicaid eligible clients, the notification is to also include the appellant's right to:
  - request a Fair Hearing by the DHSS Medicaid office at any time during the process and, if requested, to provide the Medicaid office telephone number,
  - request assistance from the DCMHS Quality Assurance (QA) Administrator in the formulation of the appeal and, if requested, to provide the QA Administrator's telephone number.

Step Three:

Upon receipt of a Step Two Appeal, the DCMHS Division Director will review the appeal and may request further assessment, further collection of data, and/or further consultation with staff or independent experts.

The appellant is to be notified of a time, date and location at which they might provide or request additional information. Based on the information received and reviewed, the Division Director will provide a written finding to the appellant by certified mail within fifteen (15) business days of receipt of the appeal with a copy of the letter to the QI Director.

The decision is to be made, with written notification to the appellant and a copy sent to the DCMHS Quality Improvement Unit, within fifteen (15) business days of receipt of the appeal. Written notification is to identify the appellant's right to request a Fair Hearing by DHSS Medicaid and include contact information for the Medicaid Fair Hearing Office.

If the appeal is denied:

- For Medicaid eligible clients, the notification is to identify their right to request a Fair Hearing by DHSS Medicaid.
- For non-Medicaid eligible clients, the decision is final at this point.

Attachments: Model Notification Forms